*Advising the Congress on Medicare issues*

# Improving providers' performance during hospitalization episodes of care

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MEDPAC

# Goal of creating “systemness”

- Health care delivery is fragmented, not coordinated
- “siloed” payment reinforces fragmentation and drives volume

- Need to change payment incentives, particularly around costly hospitalization episodes

# Average Risk-Adjusted Spending for Hospital Stay + 30 Days Post-Discharge – Chronic Obstructive Pulmonary Disease

| Type of service | Spending Low Resource Use Hospitals | Average Spending | Spending at High Resource Use Hospitals | Difference between Spending at Hospitals with High Resource Use and Average Spending | |
|---|---|---|---|---|---|
| | $ | $ | $ | % | $ |
| Total Episode | 6,372 | 7,871 | 9,748 | 23.8 | 1,877 |
| Hospital | 4,408 | 4,414 | 4,406 | -0.2 | -8 |
| Physician | 547 | 569 | 576 | 1.2 | 7 |
| Readmission | 671 | 1,543 | 2,550 | 65.3 | 1,007 |
| Post-acute care | 466 | 998 | 1,780 | 78.4 | 782 |
| Other | 280 | 347 | 436 | 25.6 | 89 |

# Readmissions

- MedPAC recommended that the Secretary reduce payment to hospitals with high readmission rates
  - Select conditions
  - Permit shared accountability; consider other approaches including virtual bundling
  - Accompanied by information on service use
- Related research and policy proposals

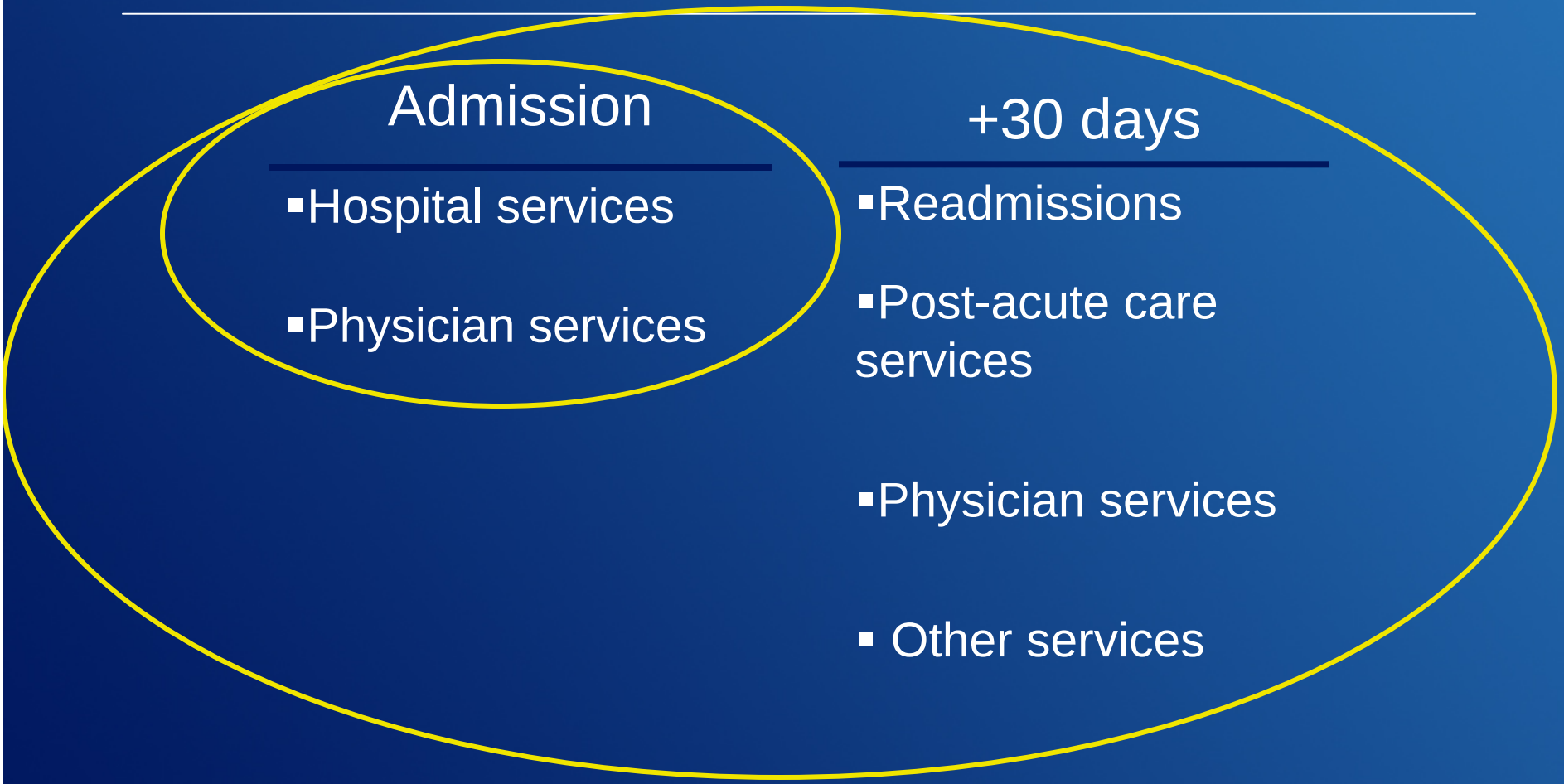
# Bundled payment

- MedPAC recommended that the Secretary conduct a pilot to test the feasibility of bundled payment around a hospitalization episode
  - Select conditions
  - Voluntary
  - Budget neutral

# Bundled payment: related research and policy proposals

- CMS ACE demonstration
- CBO budget options book
- Recommendations by the Commonwealth Fund's Commission on a High Performing Health System
- President's budget

# Concept of bundling payments around a hospitalization



# CBO discussed two bundling options

- Inpatient stay + post-acute care in 30 day post-discharge period
- Inpatient stay+ physician services during the stay

# Variations on bundled payment: virtual bundling

| Admission | +30 days |
| --- | --- |
| ▪Hospital services | ▪Readmissions |
| ▪Physician services | ▪Post-acute care services |
| | ▪Physician services |
| | ▪ Other services |

- "Virtual bundling" -- continue to pay FFS, but adjust providers' payment based on providers' relative efficiency across an episode of care

# Pros and cons of virtual bundling

Pros

- Holds variety of providers accountable over an episode, creating symmetrical alignment
- Addresses variation in PAC spending
- Mitigates incentives to stint, compared with bundling
- Does not require piloting; could be mandatory

Cons

- Does not allow the payment flexibility that bundling payment does
- Presents some administrative challenges

# Variations on bundled payment: hybrid approach

| Admission | +30 days |
| --- | --- |
| ▪ Hospital services | ▪ Readmissions |
| ▪ Physician services | ▪ Post-acute care services |
| | ▪ Physician services |
| | ▪ Other services |

- "Hybrid" – bundle payment for services delivered during the hospital stay + virtual bundling.

# Pros and Cons of the hybrid approach

Pros

- Efficiencies gained in volume of physician visits during stay and through shared accountability (i.e., gainsharing)
- A step toward more comprehensive bundling
- Good risk adjustment

Cons

- Could increase admissions
- Could create incentive to stint on care
- May not save Medicare much money
- Because bundling is limited to the stay, doesn't promote payment flexibility in post-discharge period

# Need to improve the Medicare quality infrastructure

- Payment incentives are important, but technical assistance/support may be needed
- Need to evaluate the efficacy of Medicare's resources and regulatory requirements in promoting quality improvement and "systemness"
  - Quality improvement organizations
  - Accreditation and survey process/requirements
  - Conditions of participation

# Next steps

- Perform data analysis to assess variations of bundled payment
- Investigate ways to improve the Medicare quality infrastructure